# Financial Policy North Austin Pediatrics, P.A.

Thank you for choosing us as your health care providers. The following statement is our financial policy. Your agreement to this policy is required prior to any treatment.
The parent or legal guardian is responsible for payment at the time of the visit.

**Please acknowledge each statement bellow by initialing on the line.**

**Payment**

_____ Payments are due at time of service, this includes, self pay, co-pays, deductibles, non-covered and out-of-network services.

_____ We accept VISA, MASTERCARD, cash or checks. Positive ID is required for all credit card or check payments. There is a **$25** fee for all returned checks.

_____ Patients that pay in full at the time of service will receive a 25% discount. You may then file a claim directly with your insurance company.

**Insurance**

_____ It is your responsibility to ascertain that your medical provider is a participating provider with your insurance company.

_____ If we are not in network with your insurance company, you are responsible for filing the claim with your insurance company, and payment is due at the time of service.

_____ A current insurance card and positive identification is required at each visit. Failure to provide the required information will result in forfeiture of the scheduled appointment unless cash or credit card payment can be made for the total charges of the visit.

_____ You are responsible for verifying benefits and coverage prior to any visits so that you are not billed for unanticipated charges. Some insurance companies do not cover some routine and non-routine services. Non-covered services will be billed directly to the patient. **(Common exclusions:** Well Visits; Immunizations, particularly Prevnar, Influenza and Hepatitis A; Hearing Screens; Vision Screens; and After Hour Phone Calls.**)**

_____ All outstanding balances that have not been paid within 60 days will be billed to the patient and must be paid by 90 days of date of service regardless of the insurance status. **Unpaid patient balances older than 90 days will be turned over to our collection agency. A collections charge will be accessed for these documents.**

**Late Arrival of Appointments:**

_____ **Arrival of appointment later than 15 minutes will be rescheduled unless the Providers schedule allows for the tardiness.**

**Missed Appointments**

_____ We attempt to make reminder calls for well visits, **but it is ultimately your responsibility to remember appointments**. Cancellations require 24-hour prior notice. Cancellations with less than 24-hour notice and missed appointments will be assessed at **$25**. Please schedule well checks at least one month ahead.

**After Hours phone calls/Saturday Appointments**
**(Monday- Friday AFTER 4:30pm, weekends, and holidays)**

_____ There is a **$35** charge for after hour doctor call consultations and a **$25** charge for nurse calls provided by Triage 4 Pediatrics. We will bill you for this charge for which you may then file a claim with your insurance company if this is a covered service under your policy**.**

_____ **If you are seen in the office on a Saturday/Sunday there is an additional charge of $40.00 that may or may not be covered by your insurance.**

I have read the above financial policy and I understand and agree to its terms and allow North Austin Pediatrics, P.A.'s medical providers to treat my child:

**I,** _____ **have received a copy of this document.**
PLEASE PRINT NAME

X _____ Date_____